Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	010886	A. BUILDING: _____ B. WING _____	R 09/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF MUNCIE	1601 N MORRISON RD MUNCIE, IN 47304

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on July 29, 2015. Survey dates: September 8 and 9, 2015. Facility number: 010886 Provider number: 010886 AIM number: N/A Census bed type: Residential: 74 Total: 74 Residential sample: 3 Elmcroft of Muncie was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.	{R 000}		

Indiana State Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE